



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3058-01

MFDR Date Received

MAY 10, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial explanation is understandable it does not apply in this instance. The denial code and their description are too vague for our facility to determine the basis for the denial. **This denial is not in compliance with Rule §133.3.**"

Amount in Dispute: \$400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has nothing further to add to this dispute beyond what has been communicated through its EOBs to the requestor."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 4, 2010 August 13, 2010	CPT Code 99362 – Case Management Services	\$200.00/day X 2 = \$400.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC- W1-Workers Compensation state fee schedule adjustment.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after reconsideration of services.
- 744-Does not meet the definition of case management per DWC Rule 134.202 and/or 134.204.
- 892-Denied in accordance with DWC rules and/or medical fee guideline.

Issues

1. Does the documentation support billing of CPT code 99362?

Findings

1. 28 Texas Administrative Code §134.204(e)(1)(B) states "Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

A review of the Team Treatment Meeting reports does not support the criteria that this case management service was outside of an interdisciplinary program.

28 Texas Administrative Code §134.204(e)(2) states "Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

The documentation does not support that the case management services were triggered by a change in the claimant's condition and performed for the purpose of coordinating care or return to work.

The Division finds that the requestor has not supported the services rendered met the criteria outlined in 28 Texas Administrative Code §134.204(e)(1)(B) and (e)(2). As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

7/11/2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.